HindSight

Patient Intake Form

Last Name	First Name		Middle
Birth Date	Sex: M F	Email	
Street Address	City	State	Zip
Phone	Second Phone		
Employer		Occupation	
Primary Insurance Company		Phone ( )	
Member ID #		D.O.B. If Required	
Secondary Insurance Company Name		Phone ( )	
Secondary Policy Member ID #		D.O.B. If Required	
Emergency Contact		Home Phone ( )	
Primary Care Physician:		Any Allergies?	
Do you wear sunglasses? Yes No	Do your eyes strain from using computers? Yes No	Do you smoke? Yes No	

Medical History: *Please check if you have been **diagnosed with or treated for** the following.*

Diagnosed	Yes✓	Diagnosed	Yes✓
Arthritis		High Cholesterol	
Cancer		HIV	
Cataracts		Loss Of Balance/Falls	
Diabetes		Macular Degeneration	
Eye Surgeries		Pregnant or Nursing	
Flashing Lights		Pulmonary Disease	
Glaucoma		Retinal Detachment	
Headaches/Migraines		Thyroid Problems	
Heart Disease		Vertigo	
Hepatitis		Vision Loss or Change In Vision	
High Blood Pressure		Visual Spots	

Medication/Prescription Over the counter	Dosage MG	Frequency #Times/ Day	Reason/ Condition Treated	Prescribing Doctor

I understand that under The Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

Patient Signature: _____ Date: _____